Again and again, he made personal visits to the homes of Gold Star families. He would simply show up to visit, to comfort, and to help out after families received the phone call that every military parent dreads the most. Chris formed deep friendships with many of the families, friendships that will last a lifetime. While many quote Abraham Lincoln's words, Chris lived them—through his actions, not his words, he held sacred Lincoln's pledge at Gettysburg that our country will care for ''him who has borne the battle, and his widow and his orphan.'' And so Chris did—at wakes, at funerals, in military hospitals and veterans homes, in all these difficult circumstances and the difficult days and months and years that followed, Chris Wyman kept the faith.

Chris did this for all veterans—in their spirit and many times in their memory. But he also joined a special fraternity the tight knit ''Band of Brothers'' who served with me during Swiftboat duty in Vietnam. He came to them in the 1990s and never lost touch with any of them, extending to them, as he did for so many Massachusetts veterans, total dedication and commitment through hospital visits, weddings, and funerals. It was no surprise, then, that several years ago they made him an honorary member of their ''brotherhood,'' presenting him with a blue crew member shirt, exactly the same as the ones they wore so proudly whenever they were together.

It seems fitting that Chris is retiring so close to Veterans Day—a day to honor America's veterans for their patriotism, their love of country, and their willingness to serve and to sacrifice because for these past nearly 18 years, for Chris Wyman, every day was Veterans Day. He is a shining example of service to those who have served.

Mr. President, both Chris and I are proud to be Navy men, and in the Navy, we have a special term—''Bravo Zulu'' which means ''Well Done.'' So, as one old sailor to another, with a thank you for many years of loyalty and friendship, to Chris Wyman I say ''Bravo Zulu'' for a job well done.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Mr. COBURN. Mr. President, I believe Congress should reexamine the federally mandated medical loss ratios in the Patient Protection and Affordable Care Act. Today I will outline four reasons I believe consumers will face increased costs, decreased choice, and reduced competition.

The Patient Protection and Affordable Care Act, PPACA, included a provision that requires all health plans to adhere to a medical loss ratio, MLR, established in law. The MLR refers to the percentage of premium revenues for health insurance plans spent on medical claims. Thus, if a plan received $100 of premiums and spent $85 on medical claims its MLR would be 85 percent.

Beginning no later than January 1, 2011, PPACA requires a health insurance issuer to provide an annual rebate to each enrollee if the ratio of the amount of premium revenue expended by the issuer on clinical claims and health quality costs, after accounting for several factors such as certain taxes and reinsurance, is less than 85 percent in the large group market and 80 percent in the small group and individual markets.

Supporters of PPACA tend to herald the newly created, higher MLR requirement as providing ''better value'' for policyholders compared to a lower MLR. To the untrained ear, perhaps higher MLRs sound better since they force health insurance plans are required to spend a larger percentage of each dollar on medical claims.

Jamie Robinson, a professor in the School of Public Health at the University of California at Berkley, noted that numerous organizations ''have assailed low medical loss ratios as indicators of reduction in the quality of care provided to enrollees and sponsored legislation mandating minimum ratios.'' However, he rightly concludes that while ''this is politically the most volatile and analytically the least valid use of the statistic.''

In fact, a close examination of the data suggests there are several reasons to be concerned with the one-size-fits-all federally mandated MLRs in PPACA. Here are four key reasons why PPACA's MLRs will likely negatively impact American consumers and patients.

First, insurance markets across the country threaten to destabilize. During the health reform debate, opponents of the Federal takeover of health care warned that the federally mandated MLR could endanger the high-quality health coverage many Americans enjoy because it could lead to market destabilization in some States. Under PPACA, States are permitted to adjust the percentage for the individual market only if the Secretary of Health and Human Services grants them a waiver because the Secretary determines that the health insurance market would otherwise be destabilized. Unsurprisingly, a total of 15 States have applied for a waiver from the MLR. This means that nearly one in three States has found that the MLR could destabilize their market and threaten consumers' coverage.

A review of the data shows why States are concerned. According to a study published in The American Journal of Managed Care, the specific impactof the new medical loss rules on the individual health insurance market ''has the potential to significantly affect the functioning of the individual market for health insurance.'' Using data from the National Association of Insurance Commissioners, the study's authors ''provided state-level estimates of the size and structure of the U.S. individual market from 2002 to 2009'' and then ''estimated the number of insurers expected to have MLRs below the legislated minimum and their corresponding enrollment.'' They found that in 2009, ''29 percent of insurer-state observations in the individual market would have [had] MLRs below the 80 percent minimum, corresponding to 32 percent of total enrollment. Nine states would have atleast one-half of their health insurers below the threshold.''

The study explained the impact in ''member years,'' which requires some explanation. Most health insurance policies typically have a 12-month duration, but individuals can enroll or disenroll on a monthly basis. As a result, much of the accounting and actuarial calculations that a health insurance plan makes are in member month or year terms. A member year is 12 member months and could be one individual or multiple persons. For example, if an individual is enrolled for 12 months, that is one member year, or if two people are enrolled for just 6 months each, that is one member year. The study found that ''if insurers below the MLR threshold exit the market, major coverage disruption could occur for those in poor health,'' and they ''estimated the range to be between 104,624 and 158,736 member-years.'' This empirical analysis highlights the huge disruption American consumers may face. As health insurers consolidate, stop offering some insurance products, or exit the market place altogether, Americans who like the high-quality private health plan they have will lose it. This effect would undermine the President's promise to Americans that if they like the health care plan they have, they could keep it.

There is a second concern: Instead of consumers receiving ''better value,'' consumers face increased costs. Despite often-repeated arguments that federally mandated MLRs will result in ''better value'' for consumers, there is little substance to back up this claim. The assumption behind this claim is that spending more cents of a health care dollar directly on care is inherently better. But this may not necessarily be the case. University of California, Berkley, professor Jamie Robinson has studied the issue of MLRs closely, and he noted in Health Affairs that the connection between the MLR and good value is not as clear as some would claim. ''The medical loss ratio never was and never will be an indicator of clinical quality,'' he said. In fact, Professor Robinson explained that ''neither premiums nor expenditures by themselves indicate quality of care. More direct measures of quality are available, including patient satisfaction surveys, preventive services use, and severity-adjusted clinical outcomes. Although each of these is limited in scope, they at least shed light on quality of care. The medical loss ratio does not.''

While the MLR cannot guarantee better value for consumers, it can lead to higher premium costs. As the Congressional Research Services explained,

the MLR provision in PPACA requires health insurance plans ''to pay rebates to their members if a certain percentage of their premiums are not spent on medical costs. This provision may provide an incentive for health insurance companies to reduce their compensation to and/or utilization of producers as they seek to reduce their administrative costs in relation to their medical costs.''

In this scenario, unintended consequences are important to consider. For example, an insurer may increase premiums in another product to make up for lost revenues in one where a rebate is issued. Also insurers may be incentivized to scale back utilization management techniques as a result of the MLR requirement. Accordingly the underlying medical trend which drives premium costs would increase for everyone in the risk pool, therefore leading to higher premiums for all consumers who have a health plan with that company.

Costs for consumers may also increase because of increased fraud in the system. Because insurance plans are economically discouraged from activities not directly connected to medical care, there is a perverse incentive to reduce efforts to police fraud such as conducting utilization reviews and data analysis to root out individuals who defraud the system. This is such a significant problem that it was highlighted in congressional testimony before a House subcommittee earlier this year. ''Given the role that health plan fraud prevention and detection programs have played in establishing effective models for public programs, improved data for law enforcement, and successful prevention efforts, we believe the MLR regulation's treatment of such programs should be reevaluated,'' said the witness. According to the testifying witness, the specific concern is '' the MLR regulation only provides a credit for fraud 'recoveries'—i.e., funds that were paid out to providers and then recovered under pay and chase' initiatives.'' This effectively discourages preventative measures:

The MLR regulation's treatment of fraud prevention expenses works at cross purposes with new government efforts to emulate successful private sector programs, and it is at odds with the broad recognition by leaders in the private and public sectors that there is a direct link between fraud prevention activities and improved health care quality and outcomes.

Ironically, this myopic focus on MLRs obscures the best tool to evaluate the value of a health insurance product: consumer choice. As Professor Robinson explained:

The best indicator of current and expected future value in a market economy is the willingness of the consumer to purchase and retain the product. In health care, this translates into measures of growth in enrollment and revenues, adjusted for disenrollments and changes in prices. Plans that are growing are offering something for which purchasers are willing to vote with their dollars and consumers are willing to vote with their feet.

Let me turn to my third concern. Consumers face fewer choices, less competition in the marketplace. As noted previously, the MLR threatens to destabilize several markets by pushing some health insurance plans to stop offering some insurance products, or exit the market place altogether. The Congressional Research Service explained this more in detail in a memo to Congress. CRS said the MLR ''requirements of PPACA will place downward pressures on administrative expenses, including the use of insurance producers. Thus, there will be an incentive for insurance companies to cut back on the use of producers or reduce their commissions in order to rein in their administrative expenses. Some observers, including associations of producers, have suggested that the regulatory and market changes resulting from PPACA could put producers out of business.''

The very allowance in PPACA for waivers from the MLR provision is a tacit admission the one-size-fits-all MLR approach mandated under PPACA is neither in the best interest of consumer choice nor competition among health plans in many insurance markets across the country. President Obama once publicly pushed for a government-run health plan under the auspices of more ''choice and competition,'' Unfortunately, the controversial health care law he signed is set to reduce choice and competition for millions of American consumers.

Mr. President, finally, the new mlr mandates further the government takeover of health care. Much ink has been spilled about the claim that PPACA represents a government takeover of health care. In my view, there is no disputing this claim. Even before the passage of PPACA, the nonpartisan Congressional Research Service issued a report showing that 60 percent of health care spending in the United States is controlled by State, local, and Federal governments. Now, after passage of the controversial health care law, the Federal Government will effectively regulate health insurance markets and dictate what types of health coverage Americans can buy—even penalizing employers and consumers who do not offer or purchase coverage. The law also massively expands the Medicaid Program—a program that began as a Federal-State partnership but that has evolved into a gimmick-ridden program threatening State budgets and too often promising patients coverage while denying them access to care. The law also includes hundreds of new powers for the Secretary of Health and Human Services and creates dozens of new programs that will further interfere in the practice of medicine. Yes, the law is a government takeover of health care.

Interestingly, the nonpartisan Congressional Budget Office warned that if the MLRs in PPACA were only slightly higher, PPACA would result in a complete government takeover of all health insurance. In a December 2009 analysis, CBO warned that if the MLRS were 5 percentage points higher, all private insurance would become ''an essentially governmental program.'' In fact, this CBO analysis—publicized before the health care bills became law—may be one key reason the Democrats refrained from pushing for a 90-percent MLR. CBO warned that if a 90-percent MLR were adopted, ''taken together with the significant increase in the Federal government's role in the insurance market under the PPACA, such a substantial loss in flexibility would lead CBO to conclude that the affected segments of the health insurance market should be considered part of the federal budget.'' If the bills' authors had, in fact, included a 90-percent MLR, they would have faced critics waving a CBO analysis affirming the government takeover of the health insurance industry was complete. However, even with this determination, CBO appeared to admit that determining at what point a high MLR triggers a complete government takeover of the insurance industry was not entirely cut and dry. CBO said, ''Setting a precise minimum MLR that would trigger such a determination under the PPACA is difficult, because MLRs fall along a continuum.''

Mr. President, in the end though, CBO settled on 90 percent as the tipping point, though, as they noted, any ''further expansion of the Federal Government's role in the health insurance market would make such insurance an essentially governmental program, so that all payments related to health insurance policies should be recorded as cash flows in the federal budget.'' In other words, this was just about as close as the Democrats could get without even CBO admitting it was a complete government takeover of the health insurance markets.

TRIBUTE TO STEVE ARMS

Mr. LEAHY. Mr. President, I would like to take a moment to pay tribute to Steve Arms, a technology inventor, innovator, and successful entrepreneur from Vermont.

Steve founded and developed a high tech firm, MicroStrain, which creates sophisticated micro sensors that were originally designed for arthroscopic implantation on human knee ligaments. Their sensors have since evolved and are now used by NASA, on car engines, for advanced manufacturing, on civil structures, and by the U.S. military.

When Philadelphia's Liberty Bell needed to be moved in 2003, the National Park Service used MicroStrain to detect whether the 250-year-old bell's famous crack was worsening, even by a hundredth of a hair's width. Fortunately, and thanks to MicroStrain's sensors, the Liberty Bell was moved without damage.

A product of Vermont's public education system and flagship state university, Steve grew a one-man business